

U.P. ASSOCIATION OF RURAL HEALTH SERVICES, INC.

NMHC South 805 1 st Street Menominee, MI 49858 (906)863-2315	Northern Menominee Health Center P.O. Box 159 Spalding, MI 49886 (906)497-5263 (800)270-2905	Ewen Medical- Dental Center P.O. Box 260 Ewen, MI 49925 (906)988-2210 (800)270-2904	Dickinson-Iron Dental Center 211 S. 4 th St. Ste B Crystal Falls, MI 49920 (906)875-6133	West Mackinac Dental Center P.O. Box 249 Engadine, MI 49827 (906)477-6090	Sawyer Dental Center 301 Explorer Ste B Gwinn, MI 49841 (906)372-9267
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APPLICATION FOR SLIDING FEE DISCOUNT

NAME _____ PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HAVE YOU APPLIED FOR MEDICAID WITHIN THE LAST YEAR? _____

LIST BELOW ALL HOUSEHOLD MEMBERS (INCLUDING YOURSELF)

NOTE: Dependents over age 18 will be asked to provide proof income also or apply separately.

NAME	RELATIONSHIP	AGE	NAME OF MEDICAL AND/OR DENTAL INSURANCE ON EACH PERSON	SOCIAL SECURITY #
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

APPLICANT'S EMPLOYERS _____ MONTH/YEAR STARTED _____

DEPENDENT'S EMPLOYERS _____ MONTH/YEAR STARTED _____

PLEASE READ BACK OF FORM - PROOF OF INCOME MUST ACCOMPANY SLIDING FEE APPLICATION

-CERTIFICATION-

I hereby certify that all of the information on this form is true and accurate to the best of my knowledge. I will provide available verification or documentation, as requested by the health center. I also understand that this information will be kept confidential and used only by the health center for fee adjustment purposes.

I UNDERSTAND THAT SLIDING FEE PATIENTS ARE REQUIRED TO PAY THEIR PART OF THE BILL AT TIME OF SERVICE.

 Applicant or Authorized Representative

 Date Signed

 Office Manager/Reviewer

 Date Signed

DEFINITION

INCOME -

Total annual cash receipts before taxes from all sources (including salaries, public assistance/unemployment/retirement payments, Social Security, child support, etc., but excluding gifts, receipts from sale of property or non-cash benefits such as Medicaid, food stamps, public housing, etc.). Loss carry forwards are not considered in the determination of income.

Please send proof of income with your application for sliding fee. Proof of income includes copies of both the:

- 1) 2008 federal & state income tax forms. Please include the complete tax form, including schedules A, B, C, D, E, F, Home Heating Credit, Property Tax Credit, etc. as applicable for all family members.
- 2) Current wage, social security, interest, dividend, and other income information. Other income includes the following:

- ADC and/or general assistance
- Unemployment income
- Worker's compensation
- Sick/Disability pay
- Veteran's benefits
- Pensions and annuities
- Child support received
- Alimony received
- Cash work income
- Tips
- Any other income not mentioned above

Anyone who has no income or negative or unusual income (including business income which is zero or negative) should plan to meet with the office manager to review their application.

Other applicants may be asked to meet with the office manager to explain their income information.

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SLIDING FEE WILL NOT BE APPROVED
UNTIL ALL INFORMATION IS RECEIVED